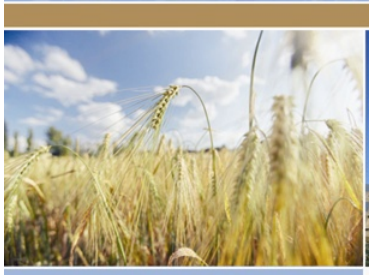
Medicare Guide to Rural Health Services Information

for Providers, Suppliers, and Physicians






CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Learning Network

DISCLAIMER

This guide was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This guide was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

MEDICARE LEARNING NETWORK

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *www.cms.hhs.gov/MLNGenInfo* on the CMS website.

MEDICARE CONTRACTING REFORM (MCR) UPDATE

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. Currently, there are three Durable Medical Equipment (DME) MACs that handle the processing of DME claims and one A/B MAC (Jurisdiction 3) to handle the processing of both Part A and Part B claims for those beneficiaries located within the states included in Jurisdiction 3. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes at *www.cms.hhs.gov/MedicareContractingReform/* on the CMS website.

NATIONAL PROVIDER IDENTIFIER (NPI) UPDATE

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated that the Secretary of the Department of Health and Human Services adopt a standard unique identifier for health care providers called the National Provider Identifier (NPI). By May 23, 2007, or May 2008 for small health plans, all health plans including Medicare, Medicaid, and private health plans and all health care clearinghouses must accept and use NPIs in standard transactions. These transactions include claims, eligibility inquiries and responses, referrals, and remittance advices. The NPI will replace health care provider identifiers that are now being used in standard transactions and will eliminate the need to use different identification numbers when conducting HIPAA standard transactions with multiple plans. Providers can apply for a NPI using one of the following methods:

- Visit *https://nppes.cms.hhs.gov* on the CMS website and complete the web-based application;
- Call (800) 465-3203 to request a paper application; or
- Submit an application in an electronic file.

The CMS website has a dedicated web page on NPI for all health care providers. Visit *www.cms.hhs.gov/NationalProvIdentStand/* on the CMS website. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation.

ICD-9 NOTICE

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

CPT DISCLAIMER--AMERICAN MEDICAL ASSOCIATION (AMA) NOTICE AND DISCLAIMER

Current Procedural Terminology (CPT) is copyright 2006 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. *CPT*® is a trademark of the American Medical Association.

TABLE OF CONTENTS

PREFACE

The *Medicare Guide to Rural Health Services Information* offers Medicare providers, suppliers, and physicians rural health information and resources in a single source. The following rural health information is included in this publication:

- **Ambulance Services**
  - Ambulance Fee Schedule Payments
  - Additional Medicare Prescription Drug, Improvement, and Modernization Act Amendments That Impact Ambulance Services
  - Air Ambulance Services

- **Critical Access Hospital**
  - Critical Access Hospital Designation
  - Critical Access Hospital Payments
  - Reasonable Cost Payment Principles That Do NOT Apply to Critical Access Hospitals
  - Election of Standard Method or Optional (Elective) Payment Method
  - Medicare Rural Pass-Through Funding for Certain Anesthesia Services
  - Health Professional Shortage Area Incentive Payments
  - Physician Scarcity Area Bonus Payments
  - Additional Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Provisions That Impact Critical Access Hospitals
  - Grants to States Under the Medicare Rural Hospital Flexibility Program

- **Federally Qualified Health Center**
  - Federally Qualified Health Center Designation
  - Covered Federally Qualified Health Center Services
  - Federally Qualified Health Center Preventive Primary Services That Are NOT Covered
  - Federally Qualified Health Center Payments
  - Medicare Prescription Drug, Improvement, and Modernization Act of 2003

- **Health Professional Shortage Area Incentive Payment**
  - Health Professional Shortage Area Incentive Payment Guidelines
  - QU and QB Modifiers

AMBULANCE SERVICES

The Balanced Budget Act of 1997 mandated the development, through negotiated rulemaking, of a fee schedule (FS) for Medicare Part B ambulance services. The FS began on April 1, 2002 and is being phased-in over a five year period.

Ambulance Fee Schedule Payments

Ambulance FS payments:

- Are based on the lower of the actual billed amount or the ambulance FS amount;
- Include a base rate payment plus a separate payment for mileage;
- Cover both the transport of the patient to the nearest appropriate facility and all items and services associated with such transport where other forms of transport are medically contraindicated;
- Do not include a separate payment for items and services such as oxygen, drugs, extra attendants, and electrocardiograms;
- Include a geographic adjustment factor known as the Geographic Practice Cost Index to reflect the relative costs of furnishing ambulance services in different areas of the country;
- For rural ambulance services, as designated by the ZIP code reported for the patient's point of pickup, include the following:
    - A 50 percent add-on to the mileage payment for the first 17 miles of a *ground* ambulance trip; and
    - A 50 percent add-on to the total payment (both mileage and base rate) for an *air* ambulance trip.

Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established an alternate FS phase-in formula for certain providers and suppliers, in which the FS portion of the blended rate is based on a specified blend of the national FS and a regional FS. If the alternate phase-in formula for a region results in a higher payment, all providers and suppliers in the region will be paid under that formula and their phase-in will last through 2010.

Additional Medicare Prescription Drug, Improvement, and Modernization Act Amendments That Impact Ambulance Services

In addition to revising the transition formula and schedule for some providers and suppliers, Section 414 of the MMA made several other temporary payment adjustments, with particular attention to ambulance services in rural areas:

- Through December 31, 2006, payments are increased by 2 percent for rural ground ambulance services and by 1 percent for urban ground ambulance services;
- Through December 31, 2008, mileage payments for ground ambulance trips that are longer than 50 miles are increased by one-quarter of the payment per mile otherwise applicable to the trip; and
- Through December 31, 2009, the base payment rate for ambulance trips that originate in rural areas with a population density in the lowest quartile of all rural county populations will be increased. The percentage increase is based on the estimated average cost per trip, not including mileage, in the lowest quartile as compared to the average cost in the highest quartile of all rural county populations.

Air Ambulance Services

Air ambulance services are covered by Medicare if the patient's condition requires air transport due to time or geographical factors. Medicare covers both fixed wing (airplane) and rotary wing (helicopter) air ambulance services.

Effective January 1, 2005, under Section 415 of the MMA, rural air ambulance services are reimbursed at the air ambulance rate if the services:

- Are reasonable and necessary based on the patient's condition at or immediately prior to transport;
- Meet specified equipment and crew requirements;
- Are deemed medically necessary. An air ambulance is deemed medically necessary when it is:
    - Requested by a physician or other practitioner who reasonably determines that land transport would threaten the patient's survival or health; or
    - Furnished according to an approved State or regional emergency medical services (EMS) agency protocol, which recommends use of an air ambulance.

The following medical personnel are qualified to order air ambulance services for Medicare beneficiaries:

- Physicians;
- Registered nurse practitioners (from the transferring hospital);
- Physician assistants (from the transferring hospital);
- Paramedic or emergency medical technicians (at the scene); and
- Trained first responders (at the scene).

In most cases, the presumption of medical necessity does not apply if:

- There is a financial or employment relationship between the person requesting the air ambulance (or his or her immediate family member) and the entity furnishing the service, or an entity under common ownership with the entity furnishing the service; or
- In the case of a State or regional EMS agency protocol, such agency has an ownership interest in the entity furnishing the service.

Payment for additional air mileage may be allowed due to circumstances beyond the pilot's control, such as:

- Military base and other restricted zones, air-defense zones, and similar Federal Aviation Administration restrictions and prohibitions;
- Hazardous weather; or
- Variances in departure patterns and clearance routes required by an air traffic controller.

To view the FS, visit *www.cms.hhs.gov/AmbulanceFeeSchedule* on the CMS website. To find additional information about ambulance policies, see Chapter 15 of the Medicare Claims Processing Manual (Pub. 100-4) and Chapter 10 of the Medicare Benefit Policy Manual (Pub. 100-2) at *www.cms.hhs.gov/Manuals/IOM/list.asp* and the Ambulance Services Provider Center at *www.cms.hhs.gov/center/ambulance.asp* on the CMS website.

CRITICAL ACCESS HOSPITAL

Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs (Flex Program), under which certain facilities participating in Medicare can become Critical Access Hospitals (CAH). The following providers may be eligible to become CAHs:

- Currently participating Medicare hospitals;
- Hospital that ceased operation during the 10 year period from November 29, 1988 through November 29, 1999; or
- Health clinics or centers (as defined by the State) that previously operated as a hospital before being downsized to a health clinic or center.

Unlike facilities such as Medicare Dependent Hospitals or Sole Community Hospitals, CAHs represent a separate provider type with their own Medicare Conditions of Participation as well as a separate payment method.

Critical Access Hospital Designation

A hospital must meet the following criteria to be designated a CAH:

- Be located in a state that has established a State Flex Program (as of August 2005, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island did not have such a program);
- Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural for purposes of becoming a CAH;
- Furnish 24-hour emergency care services, using either on-site or on-call staff;
- Provide no more than 25 inpatient beds;
- Have an average annual length of stay of 96 hours or less; and
- Be located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR be State certified by December 31, 2005 as a “necessary provider” of health care services to residents in the area.

Critical Access Hospital Payments

Medicare pays CAHs for most inpatient and outpatient services to Medicare beneficiaries on the basis of 101 percent of their allowable and reasonable costs. Under the Medicare ambulance benefit, if CAHs own and operate the only ambulance service within 35 miles, they are also paid based on a reasonable cost basis for ambulance services. CAHs are not subject to the Inpatient Prospective Payment System (IPPS) and Hospital Outpatient Prospective Payment System (OPPS).

The Medicare Part A and Part B deductible and coinsurance rules applicable to hospital services also apply to CAHs. All outpatient CAH services other than pneumococcal pneumonia vaccines, influenza vaccines, related administration of the vaccines, screening mammograms, and clinical diagnostic laboratory tests are subject to Medicare Part B deductible and coinsurance.

Reasonable Cost Payment Principles That Do NOT Apply to Critical Access Hospitals

Payment for inpatient or outpatient CAH services is NOT subject to the following reasonable cost principles:

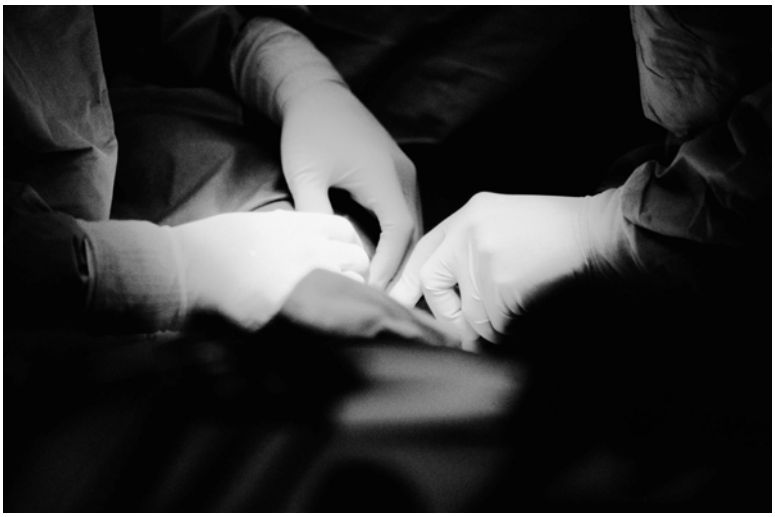
- Lesser of cost charges; and
- Reasonable compensation equivalent limits.

In addition, payment to a CAH for inpatient CAH services is not subject to ceilings on hospital inpatient operating costs or the 1-day or 3-day preadmission payment window provisions applicable to hospitals paid under the IPPS and OPPS.

Election of Standard Payment Method or Optional (Elective) Payment Method

Standard Payment Method – Cost-Based Facility Services, With Billing of Carrier for Professional Services

Under Section 1834(g) of the Social Security Act (the Act), CAHs are paid under the Standard Payment Method unless they timely elect in writing to be paid under the Optional (Elective) Payment Method. For cost reporting periods beginning on or after January 1, 2004, outpatient CAH services payments have been increased to the lesser of:



- 80 percent of the 101 percent of reasonable costs for outpatient CAH services; or
- 101 percent of the reasonable cost of the CAH in furnishing outpatient CAH services less the applicable Medicare Part B deductible and coinsurance amounts.

Payment for professional medical services furnished in a CAH to registered CAH outpatients is made by the Medicare Carrier under the Medicare Physician Fee Schedule (MPFS), as is the case when such professional services are furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services furnished by a physician or other qualified practitioner.

Optional (Elective) Payment Method – Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services (Method 2)

Under Section 1834(g) of the Act, a CAH may elect the Optional (Elective) Payment Method, under which it bills the Medicare Fiscal Intermediary (FI) for both facility services and professional services to its outpatients.

However, even if a CAH makes this election, each practitioner furnishing professional services to CAH outpatients can choose whether to:

- Reassign his or her billing rights to the CAH, agree to being included under the Optional (Elective) Payment Method, attest in writing that he or she will not bill the Carrier for professional services furnished in the CAH outpatient department, and look to the CAH for payment for the professional services; or
- File claims for his or her professional services with the Carrier for standard payment under the MPFS (i.e., either by billing directly to the Carrier or by authorizing the CAH to bill on his or her behalf via a valid reassignment of benefits).

If a physician or other practitioner reassigns his or her Part B billing rights and agrees to be included under a CAH's Optional (Elective) Payment Method, he or she must not bill the Carrier for any outpatient professional services furnished at the CAH once the reassignment becomes effective. For each physician or practitioner who agrees to be included under the Optional (Elective) Payment method and reassigns benefits accordingly, the CAH must forward a copy of the completed assignment form (Form CMS 855R) to the FI and Carrier and keep the original on file. Each practitioner must sign an attestation which clearly states that he or she will not bill the Carrier for any services furnished in the CAH outpatient department once the reassignment has been given to the CAH. This attestation will remain at the CAH. The Optional (Elective) Payment Method remains in effect for the entire cost reporting period and applies to all CAH professional services furnished in the CAH outpatient department by physicians and practitioners who have agreed to be included under the Optional (Elective) Payment Method, completed a Form CMS 855R, and attested in writing that they will not bill the Carrier for their outpatient professional services. An Optional (Elective) Payment Method election and each practitioner's agreement to be included under the election must be renewed yearly based on the cost reporting year. Form CMS 855R can be found at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp* on the CMS website.

As of January 1, 2004, payment for outpatient CAH services under the Optional (Elective) Method is based on the sum of:

- For facility services, the lesser of 80 percent of 101 percent of the reasonable cost of the CAH in furnishing CAH services OR 101 percent of the outpatient CAH services less applicable Medicare Part B deductible and coinsurance amounts; and
- For physician professional services, 115 percent of the allowable amount, after applicable deductions, under the MPFS. Payment for nonphysician practitioner professional services is 115 percent of the amount that otherwise would be paid for the practitioner's professional services under the MPFS.

To elect the Optional (Elective) Payment Method or to change a previous election, a CAH should notify the FI at least 30 days before the start of the affected cost reporting period.

Effective January 1, 2007, the payment amount is 80 percent of the MPFS for telehealth services when the distant site physician or other practitioner is located in a CAH that has elected the Optional (Elective) Payment Method and the physician or practitioner has reassigned his or her benefits to the CAH.

Medicare Rural Pass-Through Funding for Certain Anesthesia Services

CAHs may participate in the Medicare Rural Pass-Through Program to secure reasonable cost-based funding for certain anesthesia services as an incentive to continue to serve the Medicare population in rural areas. The *Code of Federal Regulations (CFR)* under 42 CFR 412.113 lists the specific requirements hospitals or CAHs must fulfill to receive rural pass-through funding from Medicare for anesthesia services furnished by Certified Registered Nurse Anesthetists (CRNA) that they employ or contract with to furnish such services to CAH patients. CAHs that qualify for a CRNA pass-through exemption receive reasonable cost for CRNA professional services, regardless of whether they choose the Standard Payment Method or the Optional (Elective) Payment Method for outpatient services.

Health Professional Shortage Area Incentive Payments

If the CAH is located within a primary medical care Health Professional Shortage Area (HPSA), physicians who furnish outpatient professional services in the CAH are eligible for a 10 percent HPSA incentive payment. If a CAH located in such a HPSA elects the Optional (Elective) Payment Method, payments to the CAH for professional services of physicians in the outpatient department will be 115 percent of the otherwise applicable MPFS amount multiplied by 110 percent.

Physician Scarcity Area Bonus Payments

Primary and specialty physicians affiliated with a CAH may also be eligible for a Physician Scarcity Area (PSA) bonus payment of five percent if the CAH is located in an area with few physicians available. One of the following modifiers must accompany the Healthcare Common Procedure Coding System code to indicate the type of physician:

- AG – Primary physician; or
- AF – Specialty physician.

If a CAH located in a PSA elects the Optional (Elective) Payment Method, payments to the CAH for professional services of physicians in the outpatient department will be 115 percent of the otherwise applicable MPFS amount multiplied by 105 percent.

Additional Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Provisions That Impact Critical Access Hospitals

For services furnished on or after January 1, 2005, Section 405(b) extends reasonable cost reimbursement for CAH costs of compensating physician assistants, nurse practitioners, and clinical nurse specialists who are on call to furnish emergency services. Under previous law, this coverage was limited to compensation for physicians who were on call to furnish emergency services.

Section 405(c) states that periodic interim payments will be paid every two weeks for CAH inpatient services furnished on or after July 1, 2004 for CAHs that apply and qualify for the periodic interim payment method.

Section 405(d) mandates that for cost reporting periods beginning on and after July 1, 2004, each physician or other practitioner furnishing professional services in the CAH is not required to reassign his or her Medicare Part B benefits to the CAH in order for the CAH to elect the Optional (Elective) Payment Method. For CAHs that elected the Optional (Elective) Payment Method before November 1, 2003 for a cost reporting period that began on or after July 1, 2001, the effective date of the rule is retroactive to July 1, 2001. For CAHs that elected the Optional (Elective) Payment Method on or after November 1, 2003, the effective date of the rule is July 1, 2004.

Under Section 405(e), beginning on January 1, 2004, CAHs may operate up to 25 beds for acute (hospital-level) inpatient care, subject to the 96-hour average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or Skilled Nursing Facility level swing bed services. Prior to January 1, 2004, CAHs could not operate more than 15 acute care beds or if they had a swing bed agreement, 25 beds.

Section 405(g) states that for cost reporting periods beginning on or after October 1, 2004, CAHs may establish psychiatric units and/or rehabilitation units that are CAH distinct parts (DP). The total number of beds in each CAH DP may not exceed ten. These beds will not count against the CAH inpatient bed limit of 25. Psychiatric and rehabilitation DPs must meet the applicable requirements for such beds in short-term general acute care hospitals, and Medicare payments will equal payments that would be made to general short-term acute care hospitals for these services (i.e., payments that are made under the Inpatient Psychiatric Prospective Payment System or the Inpatient Rehabilitation Facility Prospective Payment System). Therefore, payment for services in DP units of CAHs is not made on a reasonable costs basis.

Section 405(h) mandates that effective January 1, 2006, the provision permitting a state to waive the distance requirements for CAH status via State “necessary provider” designation has sunset. Providers that gained CAH status via “necessary provider” designations prior to January 1, 2006 are grandfathered as CAHs on and after January 1, 2006.

Grants to States Under the Medicare Rural Hospital Flexibility Program

The Flex Program, which was authorized by Section 4201 of the BBA, Public Law 105-33, consists of two separate but complementary components:

- A Medicare reimbursement program that provides reasonable cost reimbursement for Medicare-certified CAHs is administered by the Centers for Medicare & Medicaid Services; and
- A State grant program that supports the development of community-based rural organized systems of care in participating states is administered by the Health Resources and Services Administration through the Federal Office of Rural Health Policy.

To receive funds under the grant program, states must apply for the funds and engage in rural health planning through the development and maintenance of a State Rural Health Plan that:

- Designates and supports the conversions of CAHs;
- Promotes emergency medical services (EMS) integration initiatives by linking local EMS with CAHs and their network partners;
- Develops rural health networks to assist and support CAHs;
- Develops and supports quality improvement initiatives; and
- Evaluates State programs within the framework of national program goals.

To find additional information about State grants under the Flex Program, visit *www.ruralhealth.hrsa.gov* on the Web or call (301) 443-0835. To find additional information about CAHs and the Flex Program, see the Critical Access Hospital Provider Center at *www.cms.hhs.gov/center/cah.asp* and Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. To access the *CFR*, visit *www.gpoaccess.gov/cfr/index.html* on the Web. See the Health Professional Shortage Area Section of this guide for additional information about HPSA payments. To find additional information about PSA bonus payments, see the Physician Scarcity Area Bonus Payment Section of this guide. See the Swing Bed Section of this guide for additional information about swing beds. To find additional information about telehealth services, see the Telehealth Section of this guide.

FEDERALLY QUALIFIED HEALTH CENTER

The Federally Qualified Health Center (FQHC) benefit under Medicare was added effective October 1, 1991 when Section 1861(aa) of the Social Security Act (the Act) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs are “safety net” providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities. Medicare pays FQHCs, which are considered suppliers of Medicare services, an all-inclusive per visit amount based on reasonable costs with the exception of psychological or psychiatric therapeutic services. All therapeutic services furnished by clinical social workers (CSW) and clinical psychologists (CP) are subject to the outpatient mental health treatment limitation. This limit does not apply to diagnostic services.

Federally Qualified Health Center Designation

An entity may qualify as an FQHC if it is:

- Receiving a grant under Section 330 of the Public Health Service (PHS) Act;
- Receiving funding from such grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act;
- Not receiving a grant under Section 330 of the PHS Act but determined by the Secretary of the Department of Health and Human Services to meet the requirements for receiving such a grant (i.e., qualifies as a FQHC look-alike) based on the recommendation of the Health Resources and Services Administration; or
- Operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Covered Federally Qualified Health Center Services

Payments are made directly to the FQHC for covered services furnished to Medicare patients. Services are covered when furnished to a patient at the FQHC, the patient's place of residence, or elsewhere (e.g., at the scene of an accident). A FQHC generally provides the following services:

- Physicians' services;
- Services and supplies incident to the services of physicians;
- Services of nurse practitioners (NP), physician assistants (PA), certified nurse midwives (CNM), CPs, and CSWs;
- Services and supplies incident to the services of NPs, PAs, CNMs, CPs, and CSWs;
- Visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has determined that a shortage of home health agencies exists;
- Otherwise covered drugs that are furnished by, and incident to, services of physicians and nonphysician practitioners of the FQHC; and
- Outpatient diabetes self-management training and medical nutrition therapy for beneficiaries with diabetes or renal disease (effective for services furnished on or after January 1, 2006).

FQHCs also provide preventive primary health services when furnished by or under the direct supervision of a physician, NP, PA, CNM, CP, or CSW. The following preventive primary health services are covered when furnished by FQHCs to Medicare patients:

- Medical social services;
- Nutritional assessment and referral;
- Preventive health education;
- Children's eye and ear examinations;
- Well child care including periodic screening;
- Immunizations including tetanus-diphtheria booster and influenza vaccine;
- Voluntary family planning services;
- Taking patient history;
- Blood pressure measurement;
- Weight measurement;
- Physical examination targeted to risk;
- Visual acuity screening;
- Hearing screening;
- Cholesterol screening;
- Stool testing for occult blood;
- Dipstick urinalysis; and
- Risk assessment and initial counseling regarding risks.

For women only:

- Prenatal and post-partum care;
- Prenatal services;
- Clinical breast examination;
- Referral for mammography; and
- Thyroid function test.

Federally Qualified Health Center Preventive Primary Services That Are NOT Covered

FQHC preventive primary services that are NOT covered include:

- Group or mass information programs, health education classes, or group education activities including media productions and publications; and
- Eyeglasses, hearing aids, and preventive dental services.

Items or services that are covered under Part B, but are NOT FQHC services include:

- Certain laboratory services;
- Durable medical equipment, whether rented or sold including crutches, hospital beds, and wheelchairs used in the patient's place of residence;
- Ambulance services;
- The technical component of diagnostic tests such as x-rays and electrocardiograms;
- The technical component of the following preventive services:
    - Screening pap smears and screening pelvic examinations;
    - Prostate cancer screening;
    - Colorectal cancer screening tests;
    - Screening mammography; and
    - Bone mass measurements;
- Prosthetic devices that replace all or part of an internal body organ including colostomy bags, supplies directly related to colostomy care, and the replacement of such devices; and
- Leg, arm, back, and neck braces and artificial legs, arms, and eyes including replacements (if required because of a change in the patient's physical condition).

Federally Qualified Health Center Payments

Under Original Medicare, each FQHC is paid an all-inclusive per visit rate based on its reasonable costs as reported in the annual Medicare FQHC cost report, with the exception of therapeutic services furnished by CSWs and CPs, which are subject to the outpatient mental health treatment limitation. This limit does not apply to diagnostic services. The application of the outpatient mental health treatment limitation increases the beneficiary's copayment to 50 percent of the all-inclusive encounter rate.

The FQHC all-inclusive visit rate is calculated, in general, by dividing the FQHC's total allowable cost by the total number of visits for all FQHC patients. The FQHC payment methodology includes two national per-visit payment limits–one for urban FQHCs and one for rural FQHCs. For services furnished on or after January 1 of each year, the two national per-visit payment limits are increased by the Medicare Economic Index applicable to primary care physician services. A FQHC is designated as an urban or rural entity based on definitions in Section 1886(d)(2)(D) of the Act. If a FQHC is not located within a Metropolitan Statistical Area or New England County Metropolitan Area, it is considered rural and the rural limit applies. Rural FQHCs cannot be reclassified into an urban area for FQHC payment limit purposes.

Freestanding FQHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report, in order to identify all incurred costs applicable to furnishing covered FQHC services including FQHC direct costs, any shared costs applicable to the FQHC, and the FQHC's appropriate share of the parent provider's overhead costs. Form CMS-222-92 can be found at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp* on the CMS website.

Provider-based FQHCs must complete Worksheet M of Form CMS-2552-96, Hospital Cost Report, in order to identify all incurred costs applicable to furnishing covered FQHC services. At the beginning of the rate year, the Fiscal Intermediary calculates an interim all-inclusive visit rate based on either estimated allowable costs and visits from the FQHC if it is new to the FQHC Program or on actual costs and visits from the previous cost reporting period if it is not new. The FQHC's interim all-inclusive visit rate is reconciled to actual reasonable costs at the end of each cost reporting period. Form CMS-2552-96 can be found in the Provider Reimbursement Manual–Part 2 (Pub. 15-2), Chapter 36, which can be found at *www.cms.hhs.gov/Manuals/PBM/list.asp* on the CMS website.

The cost of the influenza and pneumococcal vaccines and related administration are separately reimbursed at annual cost settlement. There is a separate worksheet on the Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report to report the cost of these vaccines and related administration. These costs should never be reported on the claim when billing for FQHC services. There is no coinsurance or deductible for these services; therefore, when these vaccines are administered, the charges for the vaccines and related administration are never included with the visit charges when calculating coinsurance or deductible for the visit. When a FQHC physician, PA, NP, or CNM sees a beneficiary for the sole purpose of administering these vaccinations, the FQHC may not bill for a visit; however, the associated costs should still be included on the annual cost report.

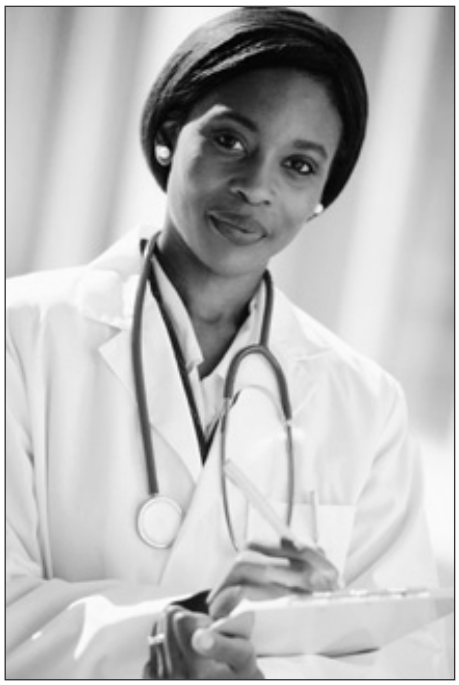
The cost of the Hepatitis B vaccine and related administration are covered under the FQHC's all-inclusive rate. If other services that constitute a qualifying FQHC visit are furnished at the same time as the Hepatitis B vaccination, the charges for the vaccine and related administration can be included in the charges for the visit when billing and in calculating the coinsurance and/or deductible. When a physician, PA, NP, or CNM sees a beneficiary for the sole purpose of administering a Hepatitis B vaccination, he or she may not bill for a visit; however, the associated costs should still be included on the annual cost report. Charges for the Hepatitis B vaccine may be included on a claim for the beneficiary's subsequent FQHC visit and in calculating the coinsurance and/or deductible.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 states that professional services furnished on or after January 1, 2005 by physicians, PAs, NPs, and CPs who are affiliated with FQHCs are excluded from the Skilled Nursing Facility Prospective Payment System, in the same manner as such services would be excluded if furnished by individuals not affiliated with FQHCs.

To find additional information about FQHCs, see Chapter 9 of the Medicare Claims Processing Manual (Pub. 100-4) and Chapter 13 of the Medicare Benefit Policy Manual (Pub. 100-2) at *www.cms.hhs.gov/Manuals/IOM/list.asp* and the Federally Qualified Health Centers Provider Center at *www.cms.hhs.gov/center/fqhc.asp* on the CMS website.

HEALTH PROFESSIONAL SHORTAGE AREA INCENTIVE PAYMENT



Effective January 1, 1991, under Section 1833(m) of the Social Security Act, Health Professional Shortage Area (HPSA) incentive payments of 10 percent will be paid on a quarterly basis to physicians who furnish medical care in geographic areas that have been designated as primary medical care HPSAs by the Health Resources and Services Administration (HRSA).

Under Section 413 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, beginning on January 1, 2005, HPSA incentive payments will be paid automatically for physician services furnished in full county primary care geographic area HPSAs and mental health HPSAs. Physicians will no longer need to identify that their services are furnished in a full county primary care geographic area HPSA. An automated file of HPSA designations will be updated on an annual basis, effective for services on or after January 1 of each calendar year. Physicians can self-designate throughout the year for newly designated HPSAs and HPSAs not included in the automated file based on the date of the data run used to create the file.

The HPSA physician incentive payment is based on the amount actually paid. Psychiatrists who furnish services in mental health HPSAs with dates of service on or after January 1, 2004 are also eligible for the incentive payment. Physicians may be entitled to a 10 percent HPSA incentive payment and/or a 5 percent Physician Scarcity Area (PSA) bonus payment for the same service as long as the area where the service is performed meets both sets of criteria. The HPSA and PSA payments are based on the paid amount of the claim.

For Professional Component/Technical Component Indicator 4 global services, the professional component is eligible for the automated HPSA payment, except for CPT® code 93015 (effective for claims received on or after July 1, 2006).

QU and QB Modifiers

For services with date of service prior to January 1, 2006, the QU or QB modifier must be submitted for Zip code areas that:

- Do not fall within a designated full county HPSA;
- Do not fall within the county based on a determination of dominance made by the United States Postal Service;
- Are partially within a partial county HPSA; or
- Are designated after the annual update is made to the automated file.

Services that fully fall within a designated area do not require the submission of a modifier in order to receive the bonus. Effective for claims with dates of service on or after January 1, 2006, the QU and QB modifiers are no longer be accepted and are replaced by the AQ modifier (Physician providing a service in a Health Professional Shortage Area).

To determine if a modifier is needed, physicians should:

- Visit *www.cms.hhs.gov/HPSAPSAPhysicianBonuses* on the Centers for Medicare & Medicaid Services (CMS) website to determine whether the location where services were furnished is within a HPSA bonus area;
- Visit the U.S. Census Bureau website at *www.Census.gov* or the Federal Financial Institutions Examination Council website at *www.ffiec.gov* to determine if the census tract where services were furnished is in an eligible HPSA; and
- Review letters of designation received from HRSA and verify eligibility of their area as a qualifying HPSA with the Carrier before submitting services with a HPSA modifier. The letters of designation must be provided as documentation to the Carrier upon request.

To find additional information about HPSAs, see the HPSA/PSA Web Page at *www.cms.hhs.gov/HPSAPSAPhysicianBonuses* and Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. See the Physician Scarcity Area Bonus Payment Section of this guide for additional information about PSAs.

HOME HEALTH

The following criteria must be met in order for the Medicare Program to reimburse a Home Health Agency (HHA) for home health (HH) services:

- The patient is an eligible Medicare beneficiary;
- The HHA that furnishes services to the patient has a valid agreement to participate in the Medicare Program and meets all of the HH Conditions of Participation;
- The patient qualifies for coverage of HH services;
- The services for which payment is claimed are covered and not otherwise excluded from payment; and
- Medicare is the appropriate payer.

Patient Eligibility for Home Health Services

The physician must certify that the patient is confined to his or her home. The patient does not have to be bedridden; however, the condition of the patient should be such that there exists a normal inability to leave home and, consequently, leaving home requires a considerable and taxing effort. If the patient does leave the home, he or she nevertheless may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to, the following:

- Attendance at an adult day center to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; and
- Receipt of outpatient chemotherapy or radiation therapy.

A beneficiary must meet the following criteria in order to qualify for HH services:

- Be under the care of a physician who is qualified to sign the physician certification and HH plan of care;
- Receive services under a plan of care established and periodically reviewed by a physician; and
- Has a need for skilled nursing care on an intermittent basis or a need for physical therapy, speech-language pathology, or occupational therapy services.

For purposes of HH benefit eligibility, intermittent means skilled nursing care that is either furnished or needed on fewer than 7 days each week or fewer than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

Home Health Prospective Payment System

The unit of payment under the HH Prospective Payment System (PPS) is a national 60-day episode rate that pays for all covered services, including medical supplies, on a prospective basis. The episode rate is adjusted by the appropriate wage index and case mix weight. The case mix weight is determined by responses to various items reported on the Outcome and Assessment Information Set. The six HH disciplines included in the 60-day episode rate are:

- Skilled nursing services;
- HH aide services;
- Physical therapy services
- Speech-language pathology services;
- Occupational therapy services; and
- Medical social services.

Also included in the 60-day episode rate are nonroutine medical supplies and therapies that could have been unbundled to Medicare Part B prior to HH PPS. When an episode contains four or fewer visits, each visit is paid the national per visit payment amount per discipline adjusted by the appropriate wage index. There are other adjustments that may be made to the 60-day episode rate. When a 60-day episode of care is curtailed, the HHA will receive a partial episode payment adjustment. When the patient experiences an unexpected change in condition, the episode payment may receive a significant change in condition adjustment.

Section 5201 of the Deficit Reduction Act (DRA) of 2005 provides that:

- HH PPS payments will be updated by a 3.3 percent HH market basket percentage increase for episodes that end on or after January 1, 2007 and before January 1, 2008;
- Effective January 1, 2007, HHAs that do not report required quality data will be subject to a 2 percent reduction to the HH market basket percentage increase applicable to HH PPS payments for that year; and
- A 5 percent add-on payment for HH services furnished in rural areas for episodes that begin on or after January 1, 2006 and before January 1, 2007.

To find additional HH information, see Chapter 7 of the Medicare Benefit Policy Manual (Pub. 100-2) at *www.cms.hhs.gov/Manuals/IOM/list.asp* and the Home Health Agency Provider Center at *www.cms.hhs.gov/center/hha.asp* on the Centers for Medicare & Medicaid Services website.

HOSPICE

Hospice care is an elected benefit covered under Medicare Part A for a beneficiary who meets all the following conditions:

- The individual is eligible for Part A;
- The individual is certified as having a terminal disease with a prognosis of six months or less if the illness runs its normal course;
- The individual receives care from a Medicare-approved hospice program; and
- The individual signs a statement indicating that he or she elects the hospice benefit and waives all rights to Medicare payments for services for the terminal illness and related conditions. Medicare will continue to pay for covered benefits that are not related to the terminal illness.

Medicare Advantage (MA) Plan enrollees eligible for Part A may elect hospice care and will remain enrolled in their MA Plan during hospice election unless they choose to voluntarily disenroll from the MA Plan.

Hospice Services

Medicare may furnish the following hospice services for the terminal illness and related conditions:

- Doctor services;
- Nursing care;
- Medical equipment;
- Medical supplies;
- Drugs for symptom control or pain relief;
- Home health aid and homemaker services;
- Physical therapy;
- Occupational therapy;
- Speech-language pathology services;
- Social worker services;
- Dietary counseling;
- Spiritual counseling;
- Grief and loss counseling for the individual and his or her family;
- Short-term care in the hospital including respite care; and
- Any covered medically necessary and reasonable services as identified by the interdisciplinary team.

Medicare will NOT pay for the following services when hospice care is chosen:

- Treatment intended to cure the terminal illness;
- Care from any provider that was not set up by the elected hospice;
- Care from another provider that is the same care that the individual must receive from his or her hospice;
- Services not covered by Medicare; and
- Services that are not medically reasonable and necessary.

Hospice care is available for 2 periods of 90 days and an unlimited number of 60 day periods. The individual must waive all rights to Medicare payments for the duration of the election/revocation of hospice care.

Certification Requirements

For the first 90-day period of hospice coverage, the hospice must obtain a certification of the terminal illness by the medical director of the hospice or the physician member of the hospice interdisciplinary team and the individual's attending physician (if he or she has an attending physician) no later than 2 calendar days after hospice care is initiated. Only a medical doctor or a doctor of osteopathy can certify or recertify a terminal illness. An attending physician is a doctor of medicine or osteopathy or a nurse practitioner who is identified by the patient, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of his or her medical care.

Written certification must be on file in the patient's medical record prior to submission of a claim to the Fiscal Intermediary and must include:

- A statement that the patient's medical prognosis is that his or her life expectancy is six months or less if the terminal illness runs its normal course;
- Specific clinical findings and other documentation that supports a life expectancy of six months or less; and
- Signature(s) of the physician(s).

If the individual lives longer than six months, he or she is still eligible for hospice care as long as there is recertification of the terminal illness.

To find additional information about hospice, see the Hospice Center Web Page at *www.cms.hhs.gov/center/hospice.asp* and Chapter 9 of the Medicare Benefit Policy Manual (Pub. 100-2) and Chapter 11 of the Medicare Claims Processing Manual (Pub. 100-4) at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the Centers for Medicare & Medicaid Services website.

MEDICARE ADVANTAGE

Medicare Advantage (MA) (Medicare Part C) is a program through which organizations that contract with the Centers for Medicare & Medicaid Services (CMS) provide or arrange for the provision of health care services to Medicare beneficiaries who:

- Are entitled to Part A and enrolled in Part B;
- Permanently reside in the service area of the MA Plan; and
- Elect to enroll in a MA Plan.

Individuals with End-Stage Renal Disease are generally excluded from enrolling in MA Plans.

New Options for Beneficiaries

Beginning in 2006, regional Preferred Provider Organization (PPO) Plans will be available throughout the U.S. In addition, in many rural areas beneficiaries will be able to choose options such as Private Fee-for-Service Plans (PFFS), Health Maintenance Organizations (HMO), and PPOs, which are currently the most popular type of employer-sponsored plan. The MA Program has created new opportunities for rural providers who may choose to:

- Enter into contracts with MA organizations to furnish health care services to MA enrollees. In general, the provisions of these contracts, including payment rates, are matters that MA organizations and providers will negotiate.
- Elect to furnish services to MA enrollees on a non-contract basis. In general, when providers furnish medically necessary covered services to MA enrollees on a non-contract basis, the plan pays providers what they would have been paid had they furnished services to Original Medicare Plan enrollees. With the exception of emergency services, non-contract services must be pre-authorized by the MA HMO Plans that do not offer a Point of Service Option. Regional and local PPO Plan enrollees may directly access non-contracting providers without a referral, although higher cost sharing will generally apply. Providers who elect to furnish services to beneficiaries enrolled in MA PFFS Plans must follow the PFFS Plan terms and conditions of payment.
- MA organizations are not required to cost settle with cost-reimbursed providers. Rather, by paying the Original Medicare “interim” rate, MA organizations satisfy the requirement that they pay at the Original Medicare rate when reimbursing non-contracting providers.

Strengthening Federally Qualified Health Centers

Federally Qualified Health Centers (FQHC) play an important role in rural health care. Several changes resulting from the MMA will help ensure that FQHCs will continue to help meet beneficiaries' health care needs. Beginning with plans offered on or after January 1, 2006, for FQHCs with contracts which specify that MA organizations will pay FQHCs an amount similar to what they pay other providers for similar services, CMS will make up the difference, if any, between such MA organizations' payments (including beneficiary cost sharing) and 100 percent of the FQHCs' reasonable costs for providing care to MA patients of MA organizations served at FQHCs.

Beginning on January 1, 2006, the Medicare Prescription Drug Plan (Medicare Part D) provides prescription drug coverage to all beneficiaries under stand-alone Prescription Drug Plans (PDP) or through MA Prescription Drug (MA-PD) Plans. PDPs offer only prescription drug coverage, and MA-PD plans offer prescription drug coverage that is integrated with the health care coverage furnished to beneficiaries under Medicare Part C.

To find additional information about the MA Program, visit *www.cms.hhs.gov/HealthPlansGenInfo/* on the CMS website. MA-PD and PDP information can be found at *www.cms.hhs.gov/PrescriptionDrugCovGenIn* on the CMS website.

MEDICARE DEPENDENT HOSPITAL

For cost reporting periods that begin on or after April 1, 1990 and end before October 1, 1994 or that begin on or after October 1, 1997 and end before October 1, 2006, a Medicare Dependent Hospital (MDH) is a rural hospital that meets the following criteria:

- It has 100 or fewer beds;
- It is not classified as a Sole Community Hospital; and
- At least 60 percent of its inpatient days or discharges were attributed to Medicare Part A beneficiaries:
    - For its cost reporting period ending on or after September 30, 1987 and before September 30, 1988;
    - For its cost reporting period beginning on or after October 1, 1986 and before October 1, 1987 (if it does not meet the preceding requirement); or
    - For at least two of the last three settled cost reporting periods.

Medicare Dependent Hospital Payments

Payment for an MDH's inpatient operating costs are the sum of the Federal payment rate plus half of the amount that exceeds the Federal payment rate based on the highest hospital specific base year costs per discharge for Medicare patients from 1982 or 1987, trended forward.

Additional payment guidelines that apply to MDHs include the following:

- A MDH is eligible for a special payment adjustment under the Hospital Inpatient Prospective Payment System;
- If its caseload falls by more than five percent due to circumstances beyond the MDH's control, it may receive payments necessary to fully compensate for fixed costs;
- A MDH does not receive preferential treatment for Disproportionate Share Hospital payments or geographic reclassification; and
- The actual payment amount for each MDH bill is determined by the Pricer based on information maintained in Fiscal Intermediary provider specific files. After the MDH's annual cost report is reviewed, lump sum adjustments may be paid.

To find additional information about MDHs, see Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website.

MEDICARE DISPROPORTIONATE SHARE HOSPITAL

The Medicare Disproportionate Share Hospital (DSH) adjustment provision under Section 1886(d)(5)(F) of the Social Security Act (the Act) was enacted by Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 and became effective for discharges occurring on or after May 1, 1986.

Methods to Qualify for Medicare Disproportionate Share Hospital Adjustment

A hospital can qualify for the Medicare DSH adjustment by using one of the following methods:

- Primary Method

The primary method is based on a complex statutory formula that results in the Medicare DSH patient percentage, which is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and Supplemental Security Income (SSI) and the percentage of total inpatient days attributable to patients eligible for Medicaid but not eligible for Medicare Part A.

Medicare Disproportionate Share Hospital Patient Percentage Formula

Disproportionate Share Patient Percentage	$\frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}}$

- Alternate Special Exemption Method

The alternate special exception method is for urban hospitals with more than 100 beds which can demonstrate that more than 30 percent of their total net inpatient care revenues come from State and local government sources for indigent care (other than Medicare or Medicaid).

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Deficit Reduction Act of 2005

Section 402 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 states that effective for discharges occurring on or after April 1, 2004, the Medicare DSH payment adjustment has been increased for rural hospitals with fewer than 500 beds and urban hospitals with fewer than 100 beds. The cap on the adjustment for these hospitals will be 12 percent, except for hospitals classified as Rural Referral Centers (RRC).

Per Section 5002 of the Deficit Reduction Act of 2005, as of October 1, 2006, Medicare Dependent Hospitals (MDH) will also be exempt from the one percent cap. The formulas to establish a hospital's Medicare DSH payment adjustment are based on the following:

- Hospital's location;
- Number of beds; and
- Status as a RRC or MDH.

Number of Beds in Hospital Determination

The chart below shows, for Medicare DSH determination purposes, how to determine the number of beds in a hospital:

Medicare Disproportionate Share Hospital Number of Beds Formula

$$\frac{\text{Number of inpatient care bed days attributable to units or wards generally payable under the Inpatient Prospective Payment System (IPPS) excluding beds otherwise countable used for outpatient observation, skilled nursing swing bed, or ancillary labor/delivery services.}}{\text{Number of days in the cost reporting period}}$$

Medicare Disproportionate Share Hospital Payment Adjustment Formulas

Under Section 1886(d)(5)(F) of the Act, additional Medicare DSH payments are made under the IPPS to acute hospitals that serve a large number of low-income Medicare and Medicaid patients. The Medicare DSH patient percentage and adjustment formulas are not applicable to Pickle Hospitals, as defined under Section 1886(d)(5)(F)(i)(II) of the Act. All PPS hospitals are eligible to receive Medicare DSH payments when their DSH patient percentage meets or exceeds 15 percent.

The following chart depicts the Medicare DSH payment adjustment formulas:

Medicare Disproportionate Share Hospital Payment Adjustment Formulas

STATUS/LOCATION NUMBER OF BEDS	THRESHOLD	ADJUSTMENT FORMULA
URBAN HOSPITALS		
0 - 99 Beds	>=15%, <20.2%	**2.5% + [.65 x (DSH pct – 15%)]** Not to Exceed 12%
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)] **Not to Exceed 12%**
100 + Beds	>=15%, <20.2%	**2.5% + [.65 x (DSH pct – 15%)]** No Cap
	>=20.2%	**5.88% + [.825 x (DSH pct – 20.2%)]** No Cap
RURAL REFERRAL CENTERS	>=15%, <20.2%	**2.5% + [.65 x (DSH pct – 15%)]** No Cap
	>=20.2%	**5.88% + [.825 x (DSH pct – 20.2%)]** No Cap
MEDICARE-DEPENDENT HOSPITALS (as of October 1, 2006)	>=15%, <20.2%	**2.5% + [.65 x (DSH pct – 15%)]** **No Cap**
	>=20.2%	**5.88% + [.825 x (DSH pct – 20.2%)]** **No Cap**
OTHER RURAL HOSPITALS		
0 - 499 Beds	>=15%, <20.2%	2.5% + [.65 x (DSH pct – 15%)] **Not to Exceed 12%**
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)] **Not to Exceed 12%**
500 + Beds	>=15%, <20.2 %	**2.5% + [.65 x (DSH pct – 15%)]** No Cap
	>=20.2%	**5.88% + [.825 x (DSH pct – 20.2%)]** No Cap

Inpatient care bed days available should be the same as Indirect Medical Education bed days. Available beds may not match the number of licensed beds.

Below is an example of the Medicare DSH patient percentage and adjustment calculation:

Hospital A has 62 beds and is located in an urban area. In fiscal year 2003, it had 5,000 total inpatient days, 1,000 Medicaid/non-Medicare days, 2,000 Medicare Part A days, and 300 Medicare Part A/SSI days. Hospital A has a Medicare DSH patient percentage of 35 percent.

Medicare Disproportionate Share Hospital Number of Beds Formula

Disproportionate Share Patient Percentage	$\frac{\text{300 Medicare SSI Days}}{\text{2,000 Total Medicare Days}} + \frac{\text{1,000 Medicaid, Non-Medicare Days}}{\text{5,000 Total Patient Days}} = .35$

Because Hospital A is located in an urban area, has less than 100 beds, and has a DSH patient percentage of more than 20.2 percent, the formula for determining the Medicare DSH adjustment is: 5.88% + [.825 x (DSH % - 20.2%)]. Urban hospitals with less than 100 beds are subject to a maximum DSH adjustment of 12 percent.

5.88% + [.825 x (35% - 20.2%)]

5.88% + 12.21% = 18.09%

Hospital A's Medicare DSH adjustment is 12%.

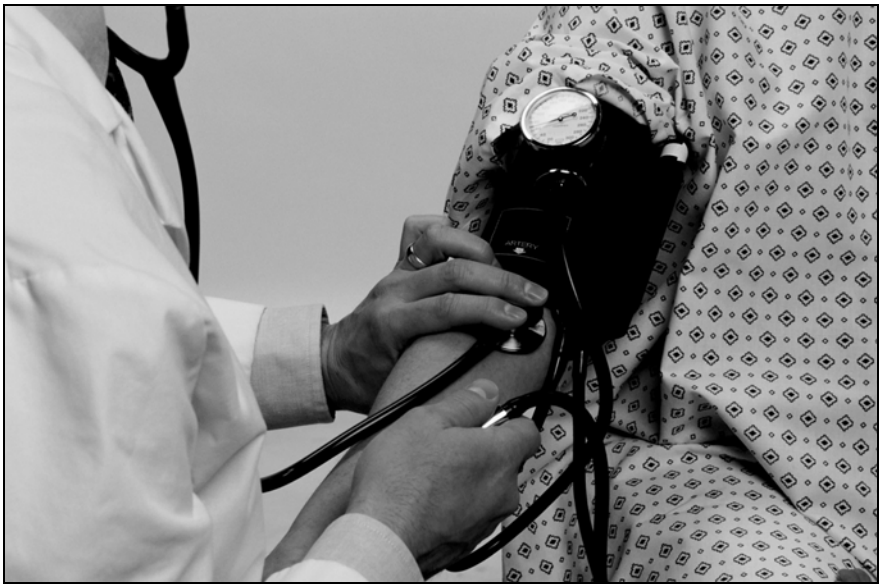
To find additional information about Medicare DSHs, see Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the Centers for Medicare & Medicaid Services website.

MEDICARE HOSPITAL RECLASSIFICATIONS

Under Section 1886(d)(10) of the Social Security Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the Inpatient Prospective Payment System. Hospitals must apply to the MGCRB to reclassify by September 1 of the year preceding the year during which reclassification is sought. In general, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassifications that become effective for the following fiscal year, which begins on October 1. Reclassifications granted by the MGCRB for hospital wage index purposes will be effective for a three-year period. Requirements applicable to hospital reclassifications by the MGCRB are located in the *Code of Federal Regulations (CFR)* under 42 CFR 412.230 through 412.280.

To find geographic reclassification applications and instructions, visit *www.cms.hhs.gov/MGCRB* on the Centers for Medicare & Medicaid Services website. To access the *CFR*, visit *www.gpoaccess.gov/cfr/index.html* on the Web.

PHYSICIAN SCARCITY AREA BONUS PAYMENT



The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 provided a bonus payment to physicians who furnish services in physician scarcity areas (PSA). As of January 1, 2005, on a quarterly basis Medicare will pay primary care physicians who furnish services in a primary care scarcity county and specialty physicians who furnish services in a specialist care scarcity county an additional amount equal to five percent of the amount paid for their professional services under the Medicare Physician Fee Schedule. Congress created the bonus payment program to make it easier to recruit and retain both primary and specialist care physicians for furnishing services to Medicare beneficiaries in a PSA. A PSA is a U.S. county with a low ratio of primary care or specialty physicians to Medicare beneficiaries.

A primary care physician is defined as a:

- General practitioner;
- Family practice practitioner;
- General internist;
- Obstetrician; or
- Gynecologist.

A specialty care physician is defined as other than a primary care physician.

The following providers are NOT eligible for the specialty physician PSA bonus payment:

- Dentists;
- Chiropractors;
- Optometrists; and
- Podiatrists.

Section 413 of the MMA states that for physician professional services furnished on or after January 1, 2005 and before January 1, 2008, a PSA bonus payment will be available as follows:

- A bonus payment equal to 5 percent of the payment amount for the services furnished will be available to primary and specialty physicians in primary care or specialist care scarcity counties with the lowest 20 percent ratio of primary care or specialty care physicians to Medicare eligible individuals residing in the county.
- To the extent that it is feasible, a rural census tract of a Metropolitan Statistical Area will be treated as an equivalent area for the purpose of qualifying as a primary care or specialist care scarcity county.
- The same services may qualify for a Health Professional Shortage Area (HPSA) incentive payment and a PSA bonus payment, resulting in a physician receiving a total 15 percent bonus payment, as long as the area where the service is furnished meets both sets of criteria.
- Determination of the bonus payment is made based on the ZIP code where the service was furnished. To find information about ZIP codes where automatic PSA payments are made, visit *www.cms.hhs.gov/HPSAPSAPhysicianBonuses* on the Centers for Medicare & Medicaid Services (CMS) website.
- The technical component of diagnostic services and services that are fully technical are not eligible for the bonus payment.

For Professional Component/Technical Component Indicator 4 global services, the professional component is eligible for the automated PSA bonus payment, except for CPT® code 93015 (effective for claims received on or after July 1, 2006).

AR Modifier

In some cases, a service may be furnished in a county that is considered a PSA, but the ZIP code is not considered dominant for that area. Consequently, the PSA bonus payment cannot be made automatically. In order to receive the PSA bonus payment for services furnished in these areas, physicians must include the AR modifier (Physician providing service in a Physician Scarcity Area) on the claim.

In order to be considered for the bonus payment, the name, address, and ZIP code of the location where the service was furnished must be included on all electronic and paper claim submissions.

To find additional information about PSAs, see the HPSA/PSA (Physician Bonuses) Web Page at *www.cms.hhs.gov/HPSAPSAPhysicianBonuses* and Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. See the Health Professional Shortage Area Incentive Payment Section of this guide for additional information about HPSAs.

PRESCRIPTION DRUG PLAN

Section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act created Medicare Part D, which provides prescription drug coverage to all beneficiaries who elect to enroll in a Prescription Drug Plan beginning on January 1, 2006.

Defined standard coverage in 2007 includes:

- An estimated average $27.35 monthly premium (this is an estimated amount; the premium depends on plan bids and which prescription drug plan or Medicare Advantage Plan the beneficiary selects);
- $265.00 yearly deductible;
- 25 percent coinsurance up to an initial coverage limit of $2,400;
- Catastrophic coverage once a beneficiary has spent $3,850 of his or her own money out-of-pocket for the year, which consists of the greater of:
    - A $2.15 copayment for generics and preferred multiple source drugs or a $5.35 copayment for all other drugs; or
    - 5 percent of the negotiated price; and
- 100 percent cost sharing once a beneficiary has reached the initial coverage limit of $2,400 but before he or she has reached the catastrophic limit of $3,850 of true out-of-pocket (TrOOP) spending.

Plans may offer alternatives to the defined standard coverage. For example, plans may reduce cost sharing or change the percentage coinsurance to actuarially equivalent flat copayments.

Coverage for those beneficiaries with incomes below 135 percent of the Federal poverty level and limited assets includes:

- A reduction in the premium for basic coverage up to the amount of the low-income premium subsidy for the region, but never to exceed the plan's premium;
- No yearly deductible;
- One of the following three copayment structures until a catastrophic limit is reached:
    - A $2.15 copayment for generics and preferred multiple source drugs or a $5.35 copayment for all other drugs;
    - A $1.00 copayment for generics and preferred multiple source drugs and a $3.15 copayment for all other drugs for beneficiaries who are eligible for full benefits under Medicare and Medicaid (full-benefit dual eligible; beneficiaries) with incomes under 100 percent of the Federal poverty level and limited savings; or
    - No copayment for residents of Skilled Nursing Facilities who are full-benefit dual eligibles; and
- Once the catastrophic limit of $3,850 out of pocket is reached, there is no copayment for all prescriptions. The government subsidy for cost sharing counts toward the out-of-pocket threshold for catastrophic coverage.

There is a low income subsidy for beneficiaries with a certain level of assets and incomes between 135 and 150 percent of the Federal poverty level. This subsidy also applies to beneficiaries with incomes below 135 percent of the Federal poverty level if their assets are such that they cannot meet the asset test for incomes below 135 percent of the Federal poverty level, but can meet the higher asset test used for those with incomes below 150 percent of the Federal poverty level. This coverage includes:

- A premium based on a sliding scale from no premium to the full amount of the premium;
- $53.00 yearly deductible;
- 15 percent coinsurance up to the catastrophic limit (the government subsidy for cost sharing counts toward the catastrophic limit); and
- Copayments not to exceed $2.15 for generic or preferred multiple source drugs or $5.35 for all other drugs once the catastrophic limit is reached.

A new exception to the anti-kickback statute has been added under which pharmacies are permitted to waive or reduce cost-sharing amounts provided they do so in an unadvertised, nonroutine manner after determining that the beneficiary in question is financially needy or after failing to collect the cost-sharing amount despite reasonable efforts. In addition, pharmacies may waive or reduce a beneficiary's Part D cost-sharing without regard to these standards for Part D enrollees eligible for the low-income subsidy provided they do not advertise that the waivers or cost-sharing reductions are available. To the extent that the party paying for cost-sharing on behalf of a Part D enrollee is a group health plan, insurance, government-funded health program, or party to a third party payment arrangement with an obligation to pay for covered Part D drugs, that party's payment will not count toward TrOOP expenditures. Thus, payments made for beneficiary cost-sharing by any entity, including a 340B pharmacy, that has an obligation to pay for covered Part D drugs on behalf of Part D enrollees or voluntarily elects to use public funds for that purpose will not count toward that beneficiary's TrOOP expenditures. By law there are several broad exceptions to the TrOOP requirements which include:

- Assistance provided by family members;
- Help from state pharmaceutical assistance programs;
- Assistance from charities unaffiliated with employers or unions including patient assistance programs; and
- Low-income cost sharing subsidies.

Rural Pharmacy Network Access

Rural pharmacies, including those located or co-located in hospital outpatient departments, Federally Qualified Health Centers, and Rural Health Clinics, may contact Part D plans to become Part D network providers under the Any Willing Provider terms and conditions. Any beneficiary cost sharing subsidized by these providers generally will not count toward the beneficiary's out-of-pocket limit (TrOOP).

To find additional information about prescription drug coverage, visit *www.cms.hhs.gov/PrescriptionDrugCovGenIn* on the Centers for Medicare & Medicaid Services website.

QUALITY IMPROVEMENT IN RURAL AREAS

The Quality Improvement Organization (QIO) Program consists of a national network of 53 QIOs that are responsible for each U.S. state, territory, and the District of Columbia. QIOs work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to ensure that patients receive the right care at the right time, particularly patients from underserved populations. The QIO Program also investigates beneficiary complaints about quality of care and safeguards the integrity of the Medicare Trust Fund by ensuring that payment is made only for medically necessary services.

8th Scope of Work

For the first time, the 8th Scope of Work includes a dedicated task for QIOs to work with Critical Access Hospitals (CAH) and rural Prospective Payment System (PPS) hospitals. The three performance improvement areas are:

- Increase the number of CAHs submitting Hospital Quality Alliance (HQA) data to the Centers for Medicare & Medicaid Services clinical warehouse for public reporting via technical assistance from the QIO;
- Improve the performance of CAH locally selected HQA measure(s) via quality improvement assistance; and
- Improve the safety climate in an Identified Participant Group of CAH/PPS rural hospitals.

It is also anticipated that during the course of the contract, new rural-sensitive measures will be added to HQA measures and submitted to the clinical warehouse for local benchmarking purposes rather than public reporting.

Organizations interested in finding additional information about QIOs may visit *www.cms.hhs.gov/QualityImprovementOrgs* on the CMS website. Medicare beneficiaries who have complaints about quality of care issues or want to file an appeal regarding a coverage decision should contact the QIO in their state. QIO telephone numbers can be found at *www.medicare.gov/Contacts/Include/DataSection/Questions/SearchCriteria.asp* on the Medicare website.

RURAL HEALTH CLINIC

The Rural Health Clinic (RHC) Program was established in 1977 to address an inadequate supply of physicians who serve Medicare and Medicaid beneficiaries in rural areas. The program provides qualifying Clinics located in rural and medically underserved communities with payment on a cost-related basis for outpatient physician and certain nonphysician services. For RHC purposes, any area that is not defined by the U.S. Census Bureau as urbanized is considered non-urbanized. RHCs are located in areas that are designated or certified by the Secretary of the Department of Health and Human Services as Health Professional Shortage Areas (HPSA) or Medically Underserved Areas (MUA). A Clinic cannot be Medicare approved concurrently as a RHC and a Federally Qualified Health Center.

Rural Health Clinic Services

RHCs furnish the following:

- Physicians' services;
- Services and supplies incident to the services of physicians;
- Services of registered dietitians or nutritional professionals for diabetes training services and medical nutrition therapy (the costs of such services are covered but not as a billable RHC visit);
- Otherwise covered drugs that are furnished by, and incident to, services of physicians and nonphysician practitioners of the RHC;
- Services of nurse practitioners (NP), physician assistants (PA), certified nurse midwives (CNM), clinical psychologists (CP), and clinical social workers (CSW);
- Services and supplies incident to the services of NPs, PAs, CNMs, CPs, and CSWs; and
- Visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has certified a shortage of home health agencies exists.

Rural Health Clinic Designation

To qualify as a Rural Health Clinic, a Clinic must be located in:

- A non-urbanized area, as defined by the U.S. Census Bureau, and in an area with one of the following current designations:
    - MUA;
    - Geographic or population-based HPSA; or
    - Governor-designated and Secretary-certified shortage area.

A shortage or underserved designation must have been designated or redesignated in the current year or in one of the previous three years. A RHC must also:

- Employ a midlevel practitioner who is available to furnish services at least 50 percent of the time the Clinic is furnishing services;
- Furnish routine diagnostic and laboratory services;
- Establish arrangements with providers and suppliers to furnish medically necessary services not available at the Clinic; and
- Furnish first response emergency care.

Rural Health Clinic Payments

Payment for RHC services furnished to Medicare patients is made on the basis of an all-inclusive rate per covered visit with the exception of psychological or psychiatric therapeutic services. All therapeutic services furnished by CSWs and CPs are subject to the outpatient mental health treatment limitation. This limit does not apply to diagnostic services. A visit is defined as a face-to-face encounter between the patient and one of the following practitioners, during which a RHC service is furnished:

- A physician;
- NP
- PA;
- CNM;
- CP;
- CSW; or
- Visiting nurse (in very limited cases).

The cost of the influenza and pneumococcal vaccines and related administration are separately reimbursed at annual cost settlement. There is a separate worksheet on the Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report to report the cost of these vaccines and related administration. These costs should never be reported on the claim when billing for RHC services. There is no coinsurance or deductible for these services; therefore, when these vaccines are administered, the charges for the vaccines and related administration are never included with the visit charges when calculating coinsurance or deductible for the visit. When a RHC physician, PA, NP, or CNM sees a beneficiary for the sole purpose of administering these vaccinations, the RCH may bill for a visit; however, the associated costs should still be included on the annual cost report.

The cost of the Hepatitis B vaccine and related administration are covered under the RCH's all-inclusive rate.

If other services that constitute a qualifying RHC visit are furnished at the same time as the Hepatitis B vaccination, the charges for the vaccine and related administration can be included in the charges for the visit when billing and in calculating the coinsurance and/or deductible. When a physician, NP, PA, or CNM sees a beneficiary for the sole purpose of administering a Hepatitis B vaccination, he or she may not bill for a visit; however, the associated costs should still be included on the annual cost report. Charges for the Hepatitis B vaccine may be included on a claim for the beneficiary's subsequent RHC visit and in calculating coinsurance and/or deductible.

Encounters at a single location on the same day with more than one health professional and multiple encounters with the same health professional constitute a single visit, except when one of the following conditions exist:

- The patient suffers an illness or injury requiring additional diagnosis or treatment subsequent to the first encounter; or
- The patient has a medical visit AND a clinical psychologist or clinical social worker visit.

Payment is made directly to RHCs for covered services furnished to a patient at the Clinic, the patient's place of residence, or elsewhere (e.g., the scene of an accident). Laboratory tests are paid separately.

The Medicare Part B deductible applies to RHC services and is based on billed charges. Noncovered expenses do not count toward the deductible. After the deductible has been satisfied, RHCs will be paid 80 percent of the all-inclusive interim encounter payment rate for each RHC visit with the exception of all psychological or psychiatric therapeutic services furnished by CSWs and CPs.

Independent RHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report, in order to identify all incurred costs applicable to furnishing covered Clinic services including RHC direct costs and any shared costs applicable to the RHC. An independent RHC is limited to the yearly national RHC per-visit payment ceiling for its encounter rate. Form CMS-222-92 can be found at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp* on the CMS website.

Provider-based RHCs must complete Worksheet M of Form CMS-2552-96, Hospital Cost Report, in order to identify all incurred costs applicable to furnishing covered Clinic services and the RHC's appropriate share of the parent provider's overhead costs. A RHC that is provider-based to a hospital with less than 50 beds is not subject to the national per-visit payment ceiling and has an encounter rate that is based on its full reasonable cost. If a RHC is in its initial reporting period, the all-inclusive visit rate is determined on the basis of a budget the RHC submits. The budget estimates the allowable cost that will be incurred by the RHC during the reporting period and the number of visits for RHC services expected during the reporting period. Form CMS-2552-96 can be found in the Provider Reimbursement Manual–Part 2 (Pub. 15-2), Chapter 36, which can be found at *www.cms.hhs.gov/Manuals/PBM/list.asp* on the CMS website.

To determine the payment rate for new RHCs and for those that have submitted cost reports, the Fiscal Intermediary (FI) applies screening guidelines and the maximum payment per-visit limitation as described below. For subsequent reporting periods, the all-inclusive visit rate is determined, at the discretion of the FI, on the basis of a budget or the prior year's actual costs and visits with adjustments to reflect anticipated changes in expenses or utilization.

In general, the payment rate is calculated by dividing the total allowable cost by the number of total visits for RHC services. At the end of the annual cost reporting period, RHCs submit a report to the FI that includes actual allowable costs and actual visits for RHC services for the reporting period and any other information that may be required. After reviewing the report, the FI divides actual allowable costs by the number of actual visits to determine a final rate for the period. Both the final rate and the interim rate are subject to screening guidelines for evaluating the reasonableness of the Clinic's productivity, payment limit, and mental health treatment limit.

Annual Reconciliation

At the end of the annual cost reporting period, the FI determines the total payment due and the amount necessary to reconcile payments made during the period with the total payment due.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 states that professional services furnished on or after January 1, 2005, by physicians, PAs, NPs, and CPs who are affiliated with RHCs are excluded from the Skilled Nursing Facility Prospective Payment System, in the same manner as such services would be excluded if furnished by individuals not affiliated with RHCs.

To find additional information about RHCs, see Chapter 9 of the Medicare Claims Processing Manual and Chapter 13 of the Medicare Benefit Policy Manual (Pub. 100-2) at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website.

RURAL REFERRAL CENTER

The Rural Referral Center (RRC) Program was established to support high-volume rural hospitals that treat a large number of complicated cases.

Rural Referral Center Program Requirements

The *Code of Federal Regulations (CFR)* under 42 CFR 412.96 contains a full description of the criteria for RRCs. In general, a Medicare participating acute care hospital is classified as a RRC if it is located in a rural area and it meets ONE of the following criteria:

1) It has 275 or more beds available for use during its most recently completed cost reporting period. If the hospital's bed count has changed, written documentation may be submitted with the application regarding one or more of the following reasons for the change:
    - The merger of two or more hospitals;
    - Acute care beds that previously were closed for renovation are reopened;
    - Acute care beds that previously were classified as part of an excluded unit are transferred to the Prospective Payment Systems; or
    - The hospital expands the number of acute care beds for use and these beds are permanently maintained for inpatients (such expansion does not include beds in corridors or other temporary beds);
2) It shows the following three elements:
    - At least 50 percent of the hospital's Medicare patients are referred from other hospitals or from physicians who are not on the staff of the hospital;
    - At least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital; and
    - At least 60 percent of all services the hospital furnishes to Medicare patients are furnished to patients who live more than 25 miles from the hospital; or

3) It meets the criteria specified in paragraphs a) and b) AND at least ONE of the criteria specified in paragraphs c), d), and e) listed below:
    a) Its case mix index for discharges during the most recent fiscal year ending at least one year prior to the beginning of the cost reporting period for which the hospital is seeking RRC status is at least equal to one of two case mix figures calculated by the Centers for Medicare & Medicaid Services (CMS) in accordance with the *CFR* under 42 CFR 412.96(c)(1)(ii).
    b) The number of discharges is at least equal to 5,000 (3,000 for an osteopathic hospital) or a threshold amount set by CMS, in accordance with the *CFR* under 42 CFR 412.96(c)(2). CMS uses data from the latest available cost report data.
    c) More than 50 percent of the hospital's active medical staff are specialists who meet the conditions specified in the *CFR* under 42 CFR 412.96(c)(3).
    d) At least 60 percent of all discharges are for inpatients who reside more than 25 miles from the hospital.
    e) At least 40 percent of all inpatients treated at the hospital are referred from other hospitals or from physicians not on the hospital's staff.

Section 4202 of the Balanced Budget Act of 1997 states that any hospitals designated as RRCs in 1991 are grandfathered as such.

To find additional RRC information, see Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website. To access the *CFR*, visit *www.gpoaccess.gov/cfr/index.html* on the Web.

SOLE COMMUNITY HOSPITAL

A hospital is eligible to be classified as a Sole Community Hospital (SCH) if it is located more than 35 miles from other like hospitals. A hospital may also be classified as a SCH if it is located in a rural area AND it meets at least ONE of the following three conditions:

1) The hospital is located between 25 and 35 miles from other like hospitals AND meets ONE of the following criteria:
    - No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital or, if larger, within its service area;
    - The hospital has fewer than 50 beds and would meet the 25 percent criterion above were it not for the fact that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital; or
    - Other like hospitals are inaccessible for at least 30 days in each of two out of three years because of local topography or prolonged severe weather conditions;
2) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of two out of three years; or
3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

Sole Community Hospital Payments

Payments to SCHs are made under the Prospective Payment System (PPS), but PPS payments are determined based on which of the following yields the greatest aggregate payment for the cost reporting period:

- The Federal rate applicable to the hospital;
- The updated hospital-specific rate based on fiscal year (FY) 1982 costs per discharge;
- The updated hospital-specific rate based on FY 1987 costs per discharge;
- For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, payments for discharges during FYs 2001, 2002, and 2003 are based on a blend of the FY 1996 hospital-specific rate and the greater of the Federal rate or the updated FY 1982 or FY 1987 hospital-specific rate; or
- For discharges beginning in FY 2004, the hospital specific rate is 100 percent of the FY 1996 hospital-specific rate.

To find additional information about SCHs, see Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the Centers for Medicare & Medicaid Services website.

SWING BED

A hospital or Critical Access Hospital (CAH) with a Medicare agreement to furnish swing bed services may use its beds as needed to furnish either acute or Skilled Nursing Facility (SNF) level care. In order to be granted approval to furnish post-acute level SNF care via a swing bed agreement, the following requirements must be met:

- For a hospital:
  - The hospital is located in a rural area;
  - The hospital has fewer than 100 beds (excluding beds for newborns and intensive care-type units);
  - The hospital has a Medicare provider agreement, as a hospital;
  - The hospital is substantially in compliance with the following SNF participation requirements:
    - Residents rights;
    - Admission, transfer, and discharge rights;
    - Resident behavior and facility practices;
    - Patient activities;
    - Social services;
    - Discharge planning;
    - Specialized rehabilitative services; and
    - Dental services;
  - The hospital has not had a nursing waiver granted as stated in the *Code of Federal Regulations (CFR)* under 42 CFR 488.54(c); and
  - The hospital has not had a swing bed approval terminated within the two years previous to application for participation.
- For a CAH:
  - The CAH is substantially in compliance with the following SNF participation requirements:
    - Residents rights;
    - Admission, transfer, and discharge rights;
    - Resident behavior and facility practices;
    - Patient activities (except for direction);
    - Social services;
    - Comprehensive assessment, comprehensive care plan, and discharge planning (with some exceptions);
    - Specialized rehabilitative services;
    - Dental services; and
    - Nutrition.

A CAH may provide no more than 25 inpatient beds. When a CAH has Medicare approval to furnish swing bed services, it may use any of its 25 inpatient beds for either acute care or SNF level care. Any bed that is within a CAH distinct unit that is Medicare certified to furnish SNF, rehabilitation, or psychiatric care does not count as part of its maximum 25 inpatient beds.

Rural hospitals and CAHs that have swing bed approval increase Medicare patient access to post-acute SNF care and maximize the efficiency of operations by meeting unpredictable demands for acute and long-term care.

Medicare patients must receive acute care as a hospital or CAH inpatient for a medically necessary stay of at least three consecutive calendar days in order to qualify for coverage of SNF level services.

Effective with cost reporting periods beginning on or after July 1, 2002, short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing bed hospitals must incorporate into the SNF Prospective Payment Systems (PPS). The SNF PPS covers all costs (ancillary, routine, and capital) related to covered services furnished to Medicare patients under a Part A covered SNF stay, with the exception of certain specified services that are separately billable to Part B. A Part A covered SNF stay in a CAH swing bed is reimbursed on the basis of reasonable costs.

To find additional information about swing beds services, see Chapter 6 of the Medicare Claims Processing Manual (Pub. 100-4) and Chapter 8 of the Medicare Benefit Policy Manual (Pub. 100-2) at *www.cms.hhs.gov/Manuals/IOM/list.asp* and the Skilled Nursing Facility Prospective Payment System Swing Bed Providers Web Page at *www.cms.hhs.gov/SNFPPS/03_SwingBed.asp* on the Centers for Medicare & Medicaid Services website. To access the *CFR*, visit *www.gpoaccess.gov/cfr/index.html* on the Web. See the Critical Access Hospital Section of this guide for additional information about CAHs.

TELEHEALTH

Effective January 1, 1999, Section 4206 of the Balanced Budget Act (BBA) authorized payment for professional consultations provided via telecommunications to Medicare beneficiaries located in rural Health Professional Shortage Areas (HPSA). Section 223 of the Benefits Improvement and Protection Act expanded the BBA telehealth provision and became effective on October 1, 2001.

Originating Sites

Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site. Originating sites (location of the beneficiary) include the following:

- Physician or practitioner offices;
- Hospitals;
- Critical Access Hospitals (CAH);
- Rural Health Clinics (RHC); and
- Federally Qualified Health Centers (FQHC).

The originating site must be located in a rural HPSA or non-Metropolitan Statistical Area county. Entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000 qualify regardless of geographic location.

Distant Site Practitioners

Practitioners at the distant site who may furnish and receive payment for telehealth services are:

- Physicians;
- Nurse practitioners (NP);
- Physician assistants (PA);
- Nurse midwives;
- Clinical nurse specialists (CNS);
- Clinical psychologists;
- Clinical social workers;
- Registered dietitians (effective January 1, 2006); and
- Nutrition professionals (effective January 1, 2006).

Telehealth Services

The current list of Medicare telehealth services include:

- Consultations (Current Procedural Terminology [CPT®] codes 99241 – 99255) (as of January 1, 2006);
- Office or other outpatient visits (CPT® codes 99201 – 99215);
- Individual psychotherapy (CPT® codes 90804 – 90809);
- Pharmacologic management (CPT® code 90862);
- Psychiatric diagnostic interview examination (CPT® code 90801) (effective March 1, 2003);
- End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment (Healthcare Common Procedure Coding System [HCPCS] codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) (effective January 1, 2005); and
- Medical nutrition therapy (MNT) (HCPCS code G0270 and CPT® codes 97802 – 97803).

For ESRD-related services, at least one face-to-face, "hands on" visit (not telehealth) must be furnished each month to examine the vascular access site by a physician, NP, PA, or CNS.

As a condition of payment, an interactive audio and video telecommunications system must be used that permits real-time communication between the physician or practitioner at the distant site and the beneficiary at the originating site. Asynchronous "store and forward" technology is permitted only in Federal telehealth demonstration programs conducted in Alaska or Hawaii.

Billing and Payment

Payment is made for the telehealth service furnished by the physician or practitioner at the distant site and a telehealth facility fee is made to the originating site. Claims for telehealth services should be submitted using the appropriate CPT or HCPCS code for the professional service and the telehealth modifier "GT" "via interactive audio and video telecommunications system" (e.g., 99243 GT). In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, the appropriate CPT code and telehealth modifier "GQ" "via asynchronous telecommunications system" (e.g., 99243 GQ) should be submitted. Claims for the facility fee should be submitted using HCPCS code Q3014, "telehealth originating site facility fee."

Physicians and practitioners at the distant site are paid 80 percent of the appropriate Medicare Physician Fee Schedule (MPFS) amount for telehealth services and bill the Medicare Carrier for covered telehealth services.

Effective January 1, 2007, the payment amount is 80 percent of the MPFS for telehealth services when the distant site physician or other practitioner is located in a CAH that has elected the Optional (Elective) Payment Method and the physician or other practitioner has reassigned his or her benefits to the CAH.

CAHs bill the Fiscal Intermediary (FI) for the services of all physicians and other practitioners who have reassigned their benefits to CAHs that have agreed to be included under the Optional (Elective) Payment Method. Hospitals and CAHs must also submit claims to the FI for any MNT services furnished to inpatients or outpatients. In all other cases, telehealth services furnished by physicians and other practitioners at the distant site must be billed to the Carrier.

For telehealth services, originating sites are paid an originating site facility fee (as described by HCPCS code Q3014). Physician and practitioner offices that serve as telehealth originating sites bill the Medicare Carrier for the originating site facility fee. Hospitals, CAHs, RHCs, and FQHCs that serve as Medicare telehealth originating sites bill the FI.

To find additional information about Medicare telehealth services, see Chapter 15 of the Medicare Benefit Policy Manual (Pub. 100-2) and Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) at *www.cms.hhs.gov/Manuals/IOM/list.asp* and the Telehealth Web Page at *www.cms.hhs.gov/Telehealth* on the Centers for Medicare & Medicaid Services website.

REFERENCE A
HELPFUL WEBSITES

Centers for Medicare & Medicaid Services' Websites

- **Ambulance Fee Schedule**
  www.cms.hhs.gov/AmbulanceFeeSchedule

- **Ambulance Services Provider Center**
  www.cms.hhs.gov/center/ambulance.asp

- **CMS Forms**
  www.cms.hhs.gov/CMSForms/CMSForms/list.asp

- **CMS Mailing Lists**
  www.cms.hhs.gov/apps/mailinglists

- **Critical Access Hospital Provider Center**
  www.cms.hhs.gov/center/cah.asp

- **Federally Qualified Health Centers Provider Center**
  www.cms.hhs.gov/center/fqhc.asp

- **Health Plans General Information (Medicare Advantage)**
  www.cms.hhs.gov/HealthPlansGenInfo

- **Home Health Agency Provider Center**
  www.cms.hhs.gov/center/hha.asp

- **Hospice Center Web Page**
  www.cms.hhs.gov/center/hospice.asp

- **Hospital Provider Center**
  www.cms.hhs.gov/center/hospital.asp

- **HPSA/PSA (Physician Bonuses)**
  www.cms.hhs.gov/HPSAPSAPhysicianBonuses

- **Internet-Only Manuals**
  www.cms.hhs.gov/Manuals/IOM/list.asp

- **Paper-Based Manuals**
  www.cms.hhs.gov/Manuals/PBM/list.asp

- **Medicare Geographic Classification Review Board**
  www.cms.hhs.gov/MGCRB

- **Medicare Helpful Contacts**
  www.medicare.gov/Contacts/Include/DataSection/Questions/SearchCriteria.asp

- **Medicare Learning Network**
  www.cms.hhs.gov/MLNGenInfo

- **Medicare Modernization Update**
  www.cms.hhs.gov/MMAUpdate/MMU/list.asp

- **MLN Matters Articles**
  www.cms.hhs.gov/MLNMattersArticles

- **OASIS (Outcome and Assessment Information Set)**
  www.cms.hhs.gov/OASIS

- **Physician's Resource Partner Center**
  www.cms.hhs.gov/center/physician.asp

- **Prescription Drug Coverage**
  www.cms.hhs.gov/PrescriptionDrugCovGenIn

- **Private Fee-for-Service Plans**
  www.cms.hhs.gov/PrivateFeeforServicePlans

- **Quality Improvement Organizations**
  www.cms.hhs.gov/QualityImprovementOrgs/

- **Regulations & Guidance**
  www.cms.hhs.gov/home/regsguidance.asp

- **Rural Health Center**
  www.cms.hhs.gov/center/rural.asp

- **Rural Hospital Flexibility Program Fact Sheet**
  www.cms.hhs.gov/media/press/release.asp?Counter=331

- **Skilled Nursing Facility PPS**
  www.cms.hhs.gov/SNFPPS/03_SwingBed.asp

- **Telehealth**
  www.cms.hhs.gov/Telehealth

Other Organizations' Websites

- **American Hospital Association Section for Small or Rural Hospitals**
  www.aha.org/aha/key_issues/rural/index.html

- **Federal Financial Institutions Examination Council**
  www.ffiec.gov

- **Government Printing Office Code of Federal Regulations**
  www.gpoaccess.gov/cfr/index.html

- **Health Resources and Services Administration**
  www.hrsa.gov/

- **National Association of Community Health Centers**
  www.nachc.org

- **National Association of Rural Health Clinics**
  www.narhc.org

- **National Rural Health Association**
  www.nrharural.org

- **Rural Assistance Center**
  www.raconline.org

- **U.S. Census Bureau**
  www.Census.gov

REFERENCE B
REGIONAL OFFICE RURAL HEALTH COORDINATORS

Below is a list of contact information for the Centers for Medicare & Medicaid Services Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues.

Region I – Boston

George Kazanjian
E-mail: *george.kazanjian@cms.hhs.gov*
Telephone: (617) 565-1282

Or

Diana Giacalone
E-Mail: *diana.giacalone@cms.hhs.gov*
Telephone: (617) 565-1205
States: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Region II – New York

Debra Smith
E-mail: *debra.smith@cms.hhs.gov*
Telephone: (212) 616-2351
States: New Jersey, New York, Puerto Rico, and Virgin Islands

Region III – Philadelphia

Patrick Hamilton
E-mail: *patrick.hamilton@cms.hhs.gov*
Telephone: (215) 861-4097
States: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and the District of Columbia

Region IV – Atlanta

Lana Dennis
E-mail: *lana.dennis@cms.hhs.gov*
Telephone: (404) 562-7379
States: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Region V – Chicago

Christine Davidson
E-mail: *christine.davidson@cms.hhs.gov*
Telephone: (312) 886-3642
States: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

Region VI – Dallas

Becky Peal-Sconce
E-mail: *becky.pealsconce@cms.hhs.gov*
Telephone: (214) 767-6444
States: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

Region VII – Kansas City

Robert Epps
E-mail: *robert.epps@cms.hhs.gov*
Telephone: (816) 426-6538
States: Iowa, Kansas, Missouri, and Nebraska

Region VIII – Denver

Lyla Nichols
E-mail: *lyla.nichols@cms.hhs.gov*
Telephone: (303) 844-6218
States: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

Region IX – San Francisco

Jane Riney
E-mail: *jane.riney@cms.hhs.gov*
Telephone: (415) 744-3759
States: Arizona, California, Hawaii, Nevada, Guam, Commonwealth of the Northern Mariana Islands, and American Samoa

Region X – Seattle

Alma Hardy
E-mail: *alma.hardy@cms.hhs.gov*
Telephone: (206) 615-2387
States: Alaska, Idaho, Oregon, and Washington

REFERENCE C
GLOSSARY

A

Appeal
Complaint a Medicare patient can make if he or she disagrees with a decision to stop services that he or she is receiving or disagrees with a decision to deny a request for health care services or payment for services already received.

B

Balanced Budget Act of 1997
Law that amended Sections of the Social Security Act to include anti-fraud and abuse provisions, program integrity, and preventive care benefits. Also established the State Children's Health Insurance Program and Medicare Advantage.

Beneficiary
Individual eligible to receive Medicare or Medicaid payment and/or services.

Benefits Improvement and Protection Act of 2000
Law that amended Titles XVIII, XIX and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid programs and the State Child Health Insurance Program.

C

Carrier
Centers for Medicare & Medicaid Services Contractor that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments.

Centers for Medicare & Medicaid Services
Federal agency that administers and oversees the Medicare Program and a portion of the State Medicaid Program.

Claim
Request for payment of Medicare benefits or services furnished by a provider or received by a beneficiary.

Code of Federal Regulations
Official compilation of federal rules and requirements.

Coinsurance
Under Original Medicare or a Private Fee-for-Service Plan, a percentage of covered charges that the Medicare beneficiary may have to pay after he or she has met the applicable deductible.

Copayment
In some Medicare health plans, the amount that is paid by the beneficiary for each medical service.

Cost-Based Reimbursement
When payment is made to a provider on the basis of its current Medicare-allowable costs.

Cost Report
Report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicare Program.

Covered Service
Reasonable and necessary service furnished to Medicare or Medicaid patients and reimbursable to the provider or beneficiary.

Critical Access Hospital
A hospital that is located in a state that has established a State Medicare Rural Hospital Flexibility Program; located in a rural area or treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural for purposes of becoming a Critical Access Hospital (CAH); furnishes 24-hour emergency care services, using either on-site or on-call staff; provides no more than 25 inpatient beds; has an average annual length of stay of 96 hours or less; and is located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR is State certified by December 31, 2005 as a “necessary provider” of health care services to residents in the area.

D

Deductible
Amount a beneficiary must pay before Medicare begins to pay for covered services and supplies.

Deficit Reduction Act of 2005
Legislation enacted on February 8, 2006 that saves funds by slowing the growth in spending for Medicare and Medicaid and other measures.

Department of Health and Human Services
Federal department that administers many health and welfare programs for citizens of the U.S and is the parent department of the Centers for Medicare & Medicaid Services.

Distinct Part of an Institution
Refers to a portion of an institution or institutional complex (e.g., a Skilled Nursing Facility [SNF], Critical Access Hospital, or hospital) that is certified to furnish SNF, Nursing Facility, psychiatric, and/or rehabilitation services.

Durable Medical Equipment
Medical equipment ordered by a physician or, if Medicare allows, a nurse practitioner, physician assistant or clinical nurse specialist for use in the home. The item must be reusable (e.g., walkers, wheelchairs, or hospital beds).

F

Federal Fiscal Year
Yearlong period that runs from October 1 through September 30.

Federally Qualified Health Center
Entity that is receiving a grant under Section 330 of the Public Health Service Ac (PHS); receiving funding from such grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act; not receiving a grant under Section 330 of the PHS Act but determined by the Secretary of the Department of Health and Human Services to meet the requirements for receiving such a grant (i.e., qualifies as a FQHC look-alike) based on the recommendation of the Health Resources and Services Administration; or operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Fee Schedule
Complete list of fees used by health plans to pay physicians and other providers.

Fiscal Intermediary
Centers for Medicare & Medicaid Services Contractor that processes claims for services covered under Medicare Part A and most types of claims for services covered under Medicare Part B.

H

Healthcare Common Procedure Coding System
The uniform method for providers and suppliers to report professional services, procedures, and supplies. It includes Current Procedure Technology codes and national alphanumeric codes.

Health Professional Shortage Area
Geographic areas that have been designated as primary medical care shortage areas where physicians who furnish medical care are entitled to a Medicare incentive payment.

Health Professional Shortage Area Incentive Payment
A 10 percent incentive payment that is made on a quarterly basis to physicians who furnish medical care in geographic areas that have been designated as primary medical care Health Professional Shortage Areas by the Health Resources and Services Administration.

Homebound
A patient who is confined to his or her home. He or she does not have to be bedridden; however, the condition of the patient should be such that there exists a normal inability to leave home and, consequently, leaving home requires a considerable and taxing effort.

Home Health
The following criteria must be met in order for the Medicare Program to reimburse a Home Health Agency (HHA) for home health (HH) services: the patient is an eligible Medicare beneficiary; the HHA that furnishes services to the patient has a valid agreement to participate in the Medicare Program and meets all of the HH Conditions of Participation; the patient qualifies for coverage of HH services; the services for which payment is claimed are covered and not otherwise excluded from payment; and Medicare is the appropriate payer.

Hospice
An elected benefit covered under Part A for a beneficiary who meets all the following conditions: The individual is eligible for Part A; the individual is certified as having a terminal disease with a prognosis of six months or less if the illness runs its normal course; the individual receives care from a Medicare-approved hospice program; and the individual signs a statement indicating that he or she elects the hospice benefit and waives all rights to Medicare payments for services for the terminal illness and related conditions. Medicare will continue to pay for covered benefits that are not related to the terminal illness.

M

Medically Necessary
Services or supplies that are proper and needed for the diagnosis or treatment of the patient's medical condition; furnished for the diagnosis, direct care, and treatment of the patient's medical condition; meet the standards of good medical practice; and are not mainly for the convenience of the patient, provider, or supplier.

Medicare Advantage
Medicare Advantage (MA) (Medicare Part C) is a program through which organizations that contract with the Centers for Medicare & Medicaid Services provide or arrange for the provision of health care services to Medicare beneficiaries (with the exception of individuals with End-Stage Renal Disease) who:

- Are entitled to Part A and enrolled in Part B;
- Permanently reside in the service area of the MA Plan; and
- Elect to enroll in a MA Plan.

Medicare Dependent Hospital
For cost reporting periods that begin on or after April 1, 1990 and end before October 1, 1994 or that begin on or after October 1, 1997 and end before October 1, 2006, a rural hospital that has 100 or fewer beds; is not classified as a Sole Community Hospital; and at least 60 percent of its inpatient days or discharges were attributed to Medicare Part A beneficiaries for its cost reporting period ending on or after September 30, 1987 and before September 30, 1988, for its cost reporting period beginning on or after October 1, 1986 and before October 1, 1987 (if it does not meet the preceding requirement), or for at least two of the last three settled cost reporting periods.

Medicare Disproportionate Share Hospital
Hospital that meets certain qualifications under either the Primary or Alternate Special Exemption Method.

Medicare Economic Index
Index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. Since 1992, the Medicare Economic Index is considered in connection with the update factor for the Medicare Physician Fee Schedule.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Comprehensive bill that was signed by President George W. Bush on December 8, 2003 that expands many parts of the Medicare Program.

O

Outcome and Assessment Information Set
Group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of Outcome-Based Quality Improvement. The Outcome and Assessment Information Set is performed on every Medicare or Medicaid patient who receives services of approved Home Health Agencies.

P

Part A of the Medicare Program
Hospital insurance that helps pay for inpatient hospital care, inpatient care in a Skilled Nursing Facility following a covered hospital stay, some home health care, and hospice care.

Part B of the Medicare Program
Medical insurance that helps pay for medically necessary services furnished by physicians in a variety of medical settings including but not limited to the physician's office, an inpatient or outpatient hospital setting, and Ambulatory Surgical Centers; home health care; ambulance services; clinical laboratory and diagnostic services; surgical supplies; durable medical equipment and supplies; and services furnished by practitioners with limited licensing such as advanced registered nurse practitioners, independently practicing physical therapists, independently practicing occupational therapists, certified registered nurse anesthetists, licensed clinical social workers, audiologists, nurse midwives, clinical psychologists, and physician assistants.

Part C of the Medicare Program
See Medicare Advantage.

Part D of the Medicare Program
Prescription drug coverage available to all beneficiaries who elect to enroll in a Prescription Drug Plan beginning on January 1, 2006.

Physician Scarcity Area
U.S. county with a low ratio of primary care or specialty physicians to Medicare beneficiaries.

Physician Scarcity Area Bonus Payment
A bonus payment that is made to physicians who furnish services in physician scarcity areas.

Physician Services
Services furnished by an individual licensed under State law to practice medicine or osteopathy.

Pricer
Software modules in Medicare claims processing systems that are specific to certain benefits and used in pricing claims, most often under Prospective Payment Systems.

Prospective Payment System
Method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount.

Q

Quality Improvement Organization Program
Program that consists of a national network of 53 Quality Improvement Organizations (QIO) that are responsible for each U.S. state, territory, and the District of Columbia. QIOs work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to ensure that patients receive the right care at the right time, particularly patients from underserved populations. It also investigates beneficiary complaints about quality of care and safeguards the integrity of the Medicare Trust Fund by ensuring that payment is made only for medically necessary services.

R

Reasonable Cost
Medicare reimbursement that is based on the actual cost of furnishing services including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the program. Fiscal Intermediaries and Carriers use the Centers for Medicare & Medicaid guidelines to determine reasonable costs incurred by individual providers in furnishing covered services to Medicare beneficiaries.

Rural Health Clinic Program
Program established to address an inadequate supply of physicians who serve Medicare and Medicaid beneficiaries in rural areas. It provides qualifying Clinics located in rural and medically underserved communities with payment on a cost-related basis for outpatient physician and certain nonphysician services.

Rural Referral Center Program
Program established to support high-volume rural hospitals that treat a large number of complicated cases. Requirements under 42 CFR 412.96 of the *Code of Federal Regulations* must be met in order to be classified as a Rural Referral Center.

S

Skilled Nursing Care
Level of care that includes services that can only be performed safely and correctly by a licensed nurse

Skilled Nursing Facility
Facility that meets specific regulatory certification requirements and primarily furnishes inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services and does not furnish the level of care or treatment available in a hospital.

Social Security Act (the Act)
Public Law 74-271 that was enacted on August 14, 1935, with subsequent amendments.

Sole Community Hospital
A hospital that is located more than 35 miles from other like hospitals or is located in a rural area and meets certain additional requirements**.**

Swing Bed
Beds that a small rural hospital can use for either Skilled Nursing Facility or hospital acute-level care on an as-needed basis if the hospital has obtained approval from the Department of Health and Human Services.

T

Telehealth
Professional consultations provided via telecommunications to Medicare beneficiaries in rural Health Professional Shortage Areas.

REFERENCE D
ACRONYMS

BBA	Balanced Budget Act
CAH	Critical Access Hospital
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
CP	Clinical Psychologist
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CSW	Clinical Social Worker
DP	Distinct Part
DRA	Deficit Reduction Act of 2005
DSH	Disproportionate Share Hospital
EMS	Emergency Medical Services
ESRD	End-Stage Renal Disease
FI	Fiscal Intermediary
FQHC	Federally Qualified Health Center
FS	Fee Schedule
FY	Fiscal Year
HCPCS	Healthcare Common Procedure Coding System
HH	Home Health
HHA	Home Health Agency
HMO	Health Maintenance Organization

HPSA	Health Professional Shortage Area
HQA	Hospital Quality Alliance
IPPS	Inpatient Prospective Payment System
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug
MCR	Medicare Contracting Reform
MDH	Medicare Dependent Hospital
MGCRB	Medicare Geographic Classification Review Board
MLN	Medicare Learning Network
MMA	Medicare Prescription Drug, Improvement, and Modernization Act
MNT	Medical Nutrition Therapy
MPFS	Medicare Physician Fee Schedule
MUA	Medically Underserved Area
NP	Nurse Practitioner
NPI	National Provider Identifier
OPPS	Outpatient Prospective Payment System
PA	Physician Assistant
PDP	Prescription Drug Plan
PFFS	Private Fee-for-Service
PHS	Public Health Service
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PSA	Physician Scarcity Area
QIO	Quality Improvement Organization

RHC	Rural Health Clinic
RRC	Rural Referral Center
SCH	Sole Community Hospital
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TrOOP	True Out-of-Pocket

February 2007
ICN: 006423

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Learning Network